ATTACHMENT XI (a)

STATE OF CALIFORNIA
EMERGENCY MEDICAL SERVICES AUTHORITY
1999 STATEWIDE Y2K HOSPITAL READINESS EXERCISE

EXERCISE BED AVAILABILITY FORM

***** This form should reflect bed status as of 0800 hrs. on September 16, 1999 *****

Please complete the information below for your facility and fax it to the normal designated county representative/agency at 1000 hrs.

1 Name of Facility:_____

3 Address:_____ 2 City:_____ Zip:_____

Disaster Coordinator:_____ 4 Telephone #:_____

FAX:_____ email:_____ 5 County:_____

6 Facility State License #: _____

As of: 0800 hrs. On: Sept. 16, 1999	Census (# of currently admitted patients) A	Estimated # of patients that you can admit at time of census with current staffing levels B	Estimated # of additional patients you can admit within two hours. C
Medical/Surgical Beds 7 (Please combine categories)			
Critical Care/ICU Beds 8 (Please combine categories)			
Pediatric Beds 9			
OB Beds 10			
All Other Beds 11 (eg. Psych, Rehab., SNF, etc.)			
Total 12			

FACILITY STATUS (Please circle one):

13 **Green** **Yellow** **Red** **Black**

"Green": Facility is able to carry out normal operational functions.

"Yellow": Some reductions in patient services, but overall, facility is able to carry out normal operational functions.

"Red": Significant reductions in patient services. Emergency services only being provided.

"Black": Facility has been severely affected. Unable to continue any services.